

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6993

06976

1. PLACE OF DEATH a. COUNTY <u>Balto. Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffer Conv. Home</u>		d. STREET ADDRESS <u>formerly of 2946 Edmondson Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>E.</u> Last <u>BATEMAN</u>		4. DATE OF DEATH Month <u>June 8,</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Peregrin Gilbert Bateman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Bateman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Daniel Joseph - 517 Title Bldg. Balto. 2, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (b) DUE TO <u>350X Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Parkinsonism</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>22 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1948</u> to <u>June 8, 1960</u> , that (I) <u>no</u> last saw the deceased alive on <u>June 1, 1960</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Lester A. Wall Jr.</u>		22b. DATE SIGNED <u>6/9/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>LESTER A. WALL JR.</u>		22d. ADDRESS <u>1039 St Paul St Baltimore 74</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/10/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto.</u>		25a. REC'D BY REGISTRAR <u>SUN 13 60</u>	
ADDRESS <u>Balto. 17</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Perna</u>	

[The body of the document contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several paragraphs, but the specific words and sentences cannot be discerned.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06977

7001

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Whiskey Bottom Road</u>		d. STREET ADDRESS <u>Whiskey Bottom Road</u>	
3. NAME OF DECEASED (Type or print) <u>Maria Christina De Jager</u> First Middle Last		4. DATE OF DEATH <u>June 3 1960</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 9 1862</u> 9. AGE (In years last birthday) <u>97</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	11. BIRTHPLACE (State or foreign country) <u>Netherlands</u>
13. FATHER'S NAME <u>Hendrik Lybrink</u>		14. MOTHER'S MAIDEN NAME <u>Anna C. Harman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>PT 1 Box 40</u>	
17. INFORMANT <u>Mrs Edward E. Kennedy</u>		Address <u>Laurel, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>492X</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Circulatory Collapse</u> (c) <u>Senility</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> , 19 to <u>1960</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>60</u> , and that death occurred at <u>3:45 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert W. Wingfield</u>		ADDRESS (Street, city or town, state) <u>Laurel, Md</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT WINGFIELD</u>		DATE SIGNED <u>June 3 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>June 6, 1960</u>	<u>St. Thoms Cem</u>	<u>Laurel, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Carrollan</u>		ADDRESS <u>Laurel, Md</u>	
24a. REC'D BY REGISTRAR <u>June 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

CERTIFICATE OF DEATH

1901

Blank lines for recording death information.

CERTIFICATE OF DEATH

Reg. Dist. **16928**

7002

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cooksville Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cooksville Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cooksville Md.		d. STREET ADDRESS 1 Cooksville Md	
3. NAME OF DECEASED (Type or print) Harry Sebastian Engel		4. DATE OF DEATH June 17 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1897
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Balto. City Jail	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry A. Engel		14. MOTHER'S MAIDEN NAME Margaret B. Squire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) g		16. SOCIAL SECURITY NO. ✓	
17. INFORMANT Mrs. Theresa J. Engel		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 wks. 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 7, 1957 to June 17, 1960 , that I last saw the deceased alive on June 15, 1960 , and that death occurred at 11:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sykesville, Md. DATE SIGNED 6.17.60			
ACTUAL SIGNATURE Sani Okutman M.D.		DATE SIGNED 6.17.60	
PHYSICIAN'S NAME (Type) Sani A. Okutman			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/21/60	22c. NAME OF CEMETERY OR CREMATORY Landon Park Cem	22d. LOCATION (City, town, or county) (State) 3801 Frederick Ave Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Low		24a. REC'D BY REGISTRAR 901.2 Hollins St	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

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CERTIFICATE OF DEATH

7003

1-1-19

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1924		Boston, Mass.	
Cause of Death		Disease		Organ		Site		Nature	
Myocardial Infarction		Coronary Artery Disease		Heart		Left Ventricle		Atherosclerosis	
Time of Death		Place of Death		Physician		Hospital		Manner of Death	
Jan 15, 1969		Home		Dr. J. Smith		St. Mary's Hospital		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

CERTIFICATE OF DEATH

Reg. Dist. NE 070

6999

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>MIAMI</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Miami</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffer's Convalescent Retreat</u>				d. STREET ADDRESS <u>12420 S.W. 191st. Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Betty Inez Mitcham</u>				4. DATE OF DEATH Month Day Year <u>June 22 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 8, 1923</u>	
9. AGE (In years lost birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Damm</u>				14. MOTHER'S MAIDEN NAME <u>Irene Majors</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-16-5363</u>		INFORMANT Address <u>Mrs. Irene Damm--Davis Avenue Granite Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, lung, with metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-20</u> , 19 <u>60</u> , to <u>6-22</u> , 19 <u>60</u> that I last saw the deceased alive on <u>6-21</u> , 19 <u>60</u> and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas F. Herbert</u> M.D.				ADDRESS (Street, city or town, state) <u>Ellicott City, Md</u>		DATE SIGNED <u>6-22-60</u>	
PHYSICIAN'S NAME (Type) <u>Thomas F. Herbert, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-25-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>S. Miami Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Miami, Florida</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>				24a. REC'D BY REGISTRAR <u>JUN 27 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	
ELLSWORTH ARMACOST 4600 Liberty Heights							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7000
CERTIFICATE OF DEATH

Reg. Dist. No. 06980

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 13	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffer's Convalescent Retreat 16 Montgomery Road		d. STREET ADDRESS 3011 Kentucky Avenue	
3. NAME OF DECEASED (Type or print) First Harry Middle R Last Nussbaum		4. DATE OF DEATH Month June Day 16 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1883
9. AGE (In years and birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) Packer		10b. KIND OF BUSINESS OR INDUSTRY Julius Gutman	
11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Nussbaum		14. MOTHER'S MAIDEN NAME Fannie Dutrow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-01-0721	
17. INFORMANT Address Earle R. Nussbaum, 318 S. Oldham Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 16, 1957, to June 2, 1960, that I last saw the deceased alive on June 2, 1960, and that death occurred at 10:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. A. Lally		ADDRESS (Street, city or town, state) 3517 Edmondson Avenue	
PHYSICIAN'S NAME (Type) L. A. LALLY M.D.		DATE SIGNED 6-17-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-20-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE JUN 20 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kneel	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **06981**

7003

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u> c. LENGTH OF STAY IN TB <u>X</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u> d. STREET ADDRESS <u>97 Mission Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Roscoe</u> Middle <u>SPENCER</u> Last <u>SPENCER</u>				4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1960</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 2, 1905</u>		9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>printer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>printing co.</u>				11. BIRTH PLACE (State or foreign country) <u>Elkin, North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ed Spencer</u>				14. MOTHER'S MAIDEN NAME <u>Molly Carter</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					
16. SOCIAL SECURITY NO. <u>027-01-7691</u>				17. INFORMANT Name <u>Miss Margaret Spencer</u> Address <u>Jessup Md</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>67 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Thomas J. Herbert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>6-24-60</u>					
EXAMINER'S NAME (Type) <u>THOMAS F. HERBERT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 27, 1960</u>				22b. DATE THEREOF <u>June 27, 1960</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Medanridge New Park</u>				22d. LOCATION (City, town, or county) (State) <u>Howard Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Donaldson</u>				ADDRESS <u>Laurel Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 28 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Robert S. [illegible]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see current certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7004

CERTIFICATE OF DEATH

Reg. Dist. No. 06982

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JESSUP ROAD BOX 196 RD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JESSUP ROAD BOX 196</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>J</u> Middle <u>WILLIAMS</u> Last		4. DATE OF DEATH <u>JUNE 30</u> Month <u>1960</u> Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 25-1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours	
11. IF UNDER 24 HRS. Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL LABORER</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GEORGE WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2118-5282</u>	
17. INFORMANT <u>Bessie Williams</u> Address <u>JESSUP ROAD BOX 196</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio-Vas. Disease</u> 442X DUE TO (b) <u>Chr. Prostatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/1/60</u> , 19 <u>60</u> , to <u>6/30/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/29/60</u> , 19 <u>60</u> , and that death occurred at <u>1:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D. <u>Savage, Md.</u>		DATE SIGNED <u>7/1/60</u>	
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>	22d. LOCATION (City, town, or county) (State) <u>near Savage Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edley Kelly</u> ADDRESS <u>1200 Snowden Pl</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 6 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	

CERTIFICATE OF DEATH

1904

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Signature of witness</p>		<p>12. Signature of witness</p>	
<p>13. Signature of witness</p>		<p>14. Signature of witness</p>	
<p>15. Signature of witness</p>		<p>16. Signature of witness</p>	
<p>17. Signature of witness</p>		<p>18. Signature of witness</p>	
<p>19. Signature of witness</p>		<p>20. Signature of witness</p>	
<p>21. Signature of witness</p>		<p>22. Signature of witness</p>	
<p>23. Signature of witness</p>		<p>24. Signature of witness</p>	
<p>25. Signature of witness</p>		<p>26. Signature of witness</p>	
<p>27. Signature of witness</p>		<p>28. Signature of witness</p>	
<p>29. Signature of witness</p>		<p>30. Signature of witness</p>	
<p>31. Signature of witness</p>		<p>32. Signature of witness</p>	
<p>33. Signature of witness</p>		<p>34. Signature of witness</p>	
<p>35. Signature of witness</p>		<p>36. Signature of witness</p>	
<p>37. Signature of witness</p>		<p>38. Signature of witness</p>	
<p>39. Signature of witness</p>		<p>40. Signature of witness</p>	
<p>41. Signature of witness</p>		<p>42. Signature of witness</p>	
<p>43. Signature of witness</p>		<p>44. Signature of witness</p>	
<p>45. Signature of witness</p>		<p>46. Signature of witness</p>	
<p>47. Signature of witness</p>		<p>48. Signature of witness</p>	
<p>49. Signature of witness</p>		<p>50. Signature of witness</p>	
<p>51. Signature of witness</p>		<p>52. Signature of witness</p>	
<p>53. Signature of witness</p>		<p>54. Signature of witness</p>	
<p>55. Signature of witness</p>		<p>56. Signature of witness</p>	
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<p>69. Signature of witness</p>		<p>70. Signature of witness</p>	
<p>71. Signature of witness</p>		<p>72. Signature of witness</p>	
<p>73. Signature of witness</p>		<p>74. Signature of witness</p>	
<p>75. Signature of witness</p>		<p>76. Signature of witness</p>	
<p>77. Signature of witness</p>		<p>78. Signature of witness</p>	
<p>79. Signature of witness</p>		<p>80. Signature of witness</p>	
<p>81. Signature of witness</p>		<p>82. Signature of witness</p>	
<p>83. Signature of witness</p>		<p>84. Signature of witness</p>	
<p>85. Signature of witness</p>		<p>86. Signature of witness</p>	
<p>87. Signature of witness</p>		<p>88. Signature of witness</p>	
<p>89. Signature of witness</p>		<p>90. Signature of witness</p>	
<p>91. Signature of witness</p>		<p>92. Signature of witness</p>	
<p>93. Signature of witness</p>		<p>94. Signature of witness</p>	
<p>95. Signature of witness</p>		<p>96. Signature of witness</p>	
<p>97. Signature of witness</p>		<p>98. Signature of witness</p>	
<p>99. Signature of witness</p>		<p>100. Signature of witness</p>	